Meeting Notes
Framework for Payment Subcommittee Meeting
October 26, 2011

Members present: **Paula Block**, CHC-Montana Primary Care Association; **Dr. Doug Carr**, Billings Clinic; **Dr. Paul Cook**, Rocky Mountain Health Network; **Dr. Janice Gomersall**, Montana Academy of Family Physicians; **Dr. Jonathan Griffin**, St. Peter's Medical Group; **Dr. Jay Larson**, Independent Provider**; Kirsten Mailloux**, EBMS; **Dr. Fred Olson**, BCBS MT; **Bill Pfingsten**, Bozeman Deaconess Health Group; **Dr. Tom Roberts**, Western Montana Clinic; **Dr. Bob Shepard**, New West Health Services; **Dr. Jerry Speer**, Benefis Health System

Interested Parties present: **Rob Stenger**, Grant Creek Family Practice, St. Patrick's Hospital**; Kristina Davis**, Children's Defense Fund; Will Robinson, NCQA; **Kris Juliar,** Montana Office of Rural Health; Nancy Wikle, DPHHS Medicaid, Care Management Supervisor; Myrna Seno, Mountain Pacific Quality Health; **Claudia Stephens**, Montana Migrant and Seasonal Farm Worker Council; **Janice Mackenson,** Mountain Pacific Quality Health

1. The meeting was called to order by Chair, Doug Carr at 2:30 pm and roll call was taken.

2. The group agreed that written notes are not official documents. They become official only as reported to the Advisory Council. The group reviewed and agreed the notes reflected the discussion of the subcommittee.

3. CMS Comprehensive Primary Care Initiative was briefly reviewed as most members were present in the preceding Quality Metrics subcommittee. Seven venues across the country will be accepted to incorporate Medicare with medical home initiatives in their states. It is a 4-year initiative that requires commercial payers to be involved. We are involving the entire state. The initiative provides PMPM payment, risk adjusted between $8-$40 PMPM added to commercial side. The reimbursement is reduced in years 3 and 4 when shared-savings should kick in. Those savings are attributed to the practices. New West, BCBS, EMBS, Allegiance, have pledged to submit proposals. Medicaid is interested and has drafted a letter for approval. After the letters have been submitted, TPA's will be talking to the large self-funded plans through MAHCP. There was discussion that the group may want to contact MUST.

CMS is looking for two rural states and with a state-wide reach. Potential problems: 1-They are committed to a shared -savings model. We are not. 2-The Risk stratification based on patient characteristics may also be a problem. Some members noted that the care management payment and payment for quality should qualify as the needed risk adjustment factor. Members thought that CMS will base payment on shared savings in the total market—and apply that to practices based on quality

and population in Medicare. This may be congruent with our model. Medicare will be driving this, so we may need to be flexible with our model in terms of shared savings and risk adjustment.

4. Review of straw man proposal

The subcommittee will continue to refine the attribution component. It is clear that all members in a contractual group will be members, not only those with FFS payment based on RVUs. Both payers and providers must create an environment to encourage patient selection at benefits design or intake level—but will need to have a backup plan based on utilization. The system will need reconciliation between provider practice and payer claims attributes. It probably can't be done at a clearing house level. There are many patients that have never seen a doctor—they won't make a selection. There will need to be an on-going effort on patients for whom the selection is not simple.

Medicaid is required to have patient attribution. They follow an algorithm and provide a list of patients to their providers who get a participation fee. About 75% of patients select their provider. The remainder is assigned an enrollment broker who applies various utilization or geographic rules.

Some members were concerned that providers would take too many patients and be unable to accomplish the prevention.

The structural components of payment were reviewed.

1. FFS continues
2. Participation--providers receive PMPM payment for all patients; automated at the payer level
3. Care Management--based on types and number of diagnoses—provider will bill payers on a monthly or quarterly basis
4. Quality improvement—this payment will be an annual process following adjudication. It is based on work of QM subcommittee and initially will consist of reporting. After a year the payment can be based on achievement of benchmark. Uniform reporting in a state-wide data system with real-time reporting is a requirement so providers can make adjustments in practice during the year to meet goals.

Medicaid wanted the group to consider that it has month to month eligibility. It would be hard to go back quarterly for a care management payment. Payers stressed the need for some flexibility in frequency due to limitations of claims payment systems. We should put out recommendations and then have payers try to get buy in. Medicaid's care management is PMPM, but it is not risk adjusted. Provider-based billing does not impact PMPM.

Dr. Carr agreed to write up the straw proposal, send it out, and ask for feedback. Payers can then take it to their people.

5. Attributes of a data repository
    - Must be uniform statewide to achieve quality improvement reporting

- Must be able to report real-time measures, not just an annual measure of quality
- The care management fee also requires a uniform state-wide repository. Relying on payer claims alone is not good enough.

General discussion on quality- The group discussed if we can go forward without a uniform state-wide data repository. Members stated that we need to be able to start without having everything in place. The conversations will lead us there. We need to keep talking. We need transition time. Not everything has to be in place on day one. We can move forward with some elements and wait on others. Transformation has to be a stepped approach, so let's start.

There was discussion on BCBS' current medical home program. The opinion was expressed that it is not patient-centered. Patients have to know they are part of something. BCBS responded that it is up to providers to decide if they are going to notify patients. One member stated that without patent buy-in, there are limits to the effectiveness of a medical home. That's where the effort needs to be. Another member countered that when providers know who is on their panel they will do better regardless of whether the patient knows. The biggest value is in identifying gaps in care, not patient participation.

A question was raised about whether payers pay based on only the impact to their own policy holders or globally on the quality produced across the panel. A provider responded that it's more important to agree on the quality metrics, as providers will treat all patients the same—including the uninsured. Another member questioned whether providers might target BCBS patients for certain types of care if there is more incentive to do so. Payers may need to rely on provider-generated reports or more global payments, not just that payer's policyholders. The uninsured can only be brought in if we use a more global population metric. The concept is population management.

The participation and care management payment components might need to be member-based, but the quality improvement component needs to be globally-based and paid by all participating payers.

The group wondered if there needs to be more discussion on a shared-savings component if we want to and are invited to proceed with the CMS CPCI RFP (Centers for Medicare and Medicaid Services, Comprehensive Primary Care Initiative, Request for Proposals)

Decisions were not reached on these discussion items

6. Next steps:
    - further discuss quality measures
    - members to respond to written straw proposal to be sent by Dr. Carr
    - Payers will look at code sets and claims systems.
    - CSI to determine if we can have some kind of standard language around payment